

Preparing for leadership in General Practice: a qualitative exploration of how GP trainees learn about leadership

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ABSTRACT

Background and Objectives

The recent rise to prominence of leadership in healthcare worldwide has prompted those involved in medical education to consider how to facilitate the learning of effective leadership. The focus of research has been on the effectiveness of formal curriculum activities, but curricular theory suggests that trainee doctors are also likely to learn about leadership through the informal curriculum. The apparent lack of medical education literature relating to the study of leadership learning through the informal curriculum indicates that there is a need to better understand how trainee doctors learn about leadership. Our objective was to explore how GP trainees learn about leadership in their GP training practices.

Methods

Epistemologically grounded in social constructionism, this research involved 15 semi-structured interviews with GP trainees at the point of completing their training. Interviews were conducted using an online video conferencing method, audio-taped, transcribed, and analysed using thematic framework analysis to identify ways in which trainees had learned about leadership.

Results

Trainees described learning through observation of leadership behaviour across the entire practice team, and we identified three learning processes which contributed to leadership development; evaluating leadership, formulating views on leadership, and

constructing a personal leadership identity. Other factors operating within the informal curriculum included leadership terminology, and the quality of relationships and networks. Paradoxically, a role model's fallibility as a leader could positively influence leadership learning.

Conclusions

Based on the findings of the study, we present a model which describes the process of informal leadership learning. A deeper understanding of the processes of leadership learning may enhance the facilitation of leadership learning by trainers but also by the wider clinical team, and positively influence the delivery and content of formal leadership courses.

INTRODUCTION

The rise of healthcare leadership

In the last ten years several identifiable drivers have raised the profile of healthcare leadership. Separate reports from the UK and from Australia have highlighted failures in healthcare leadership which were attributed to traditional leadership hierarchies [1,2], and focused attention on a more collective model of leadership, shared and distributed across the organisation, and undertaken by those best suited to the particular situation [3]. Distributed leadership is reported to have beneficial effects on the quality of care and patient safety [4]. Furthermore, effective shared leadership which values the staff voice and promotes a sense of team identity, can potentially increase staff morale [5]. In the UK, the General Medical Council has stressed the importance of leadership in terms of observable behaviours among clinicians such as building positive working relationships, the demonstration of flexibility and adaptability, and effective inter-disciplinary team-working [6]. The Royal College of General Practitioners (RCGP) curriculum [7] views clinical leadership as a means of improving the quality of care for patients, and states that doctors have a leadership role within society and must take a role in leading change in service delivery.

Learning about leadership

The rise to prominence of healthcare leadership has been associated with a wide range of initiatives aimed at promoting leadership development. Large-scale reviews of faculty leadership development programmes in academic medical centres across the USA and in Canada and Scandinavia, which included workshops, short courses and fellowships, identified a modest level of impact on knowledge, skills and attitudes [8,9].

In the UK, medical students and doctors in training have positively evaluated the impact of leadership development interventions such as taught programme days, on-line discussions, regular facilitated discussions, and practice-based projects [10-15]. In Canada and New Zealand, professional standards for medical students and specialty trainees now include leadership learning outcomes [16,17], and in the UK the RCGP has integrated leadership training into its curriculum in order to ensure the early development of clinical leadership skills among newly qualified General Practitioners (GPs, or family doctors) [18]. The focus of many leadership training programmes has been on the development of personal and interpersonal leadership competencies, and this has led to a proliferation of leadership competency frameworks, as different medical and healthcare leadership associations across the world seek to define their own preferred leadership outcomes [19-22].

The formal and informal curricula in medical education

This research emphasis on the effectiveness of leadership development interventions, often with reference to competency frameworks, has given a disproportionate level of significance to the formal curriculum in terms of understanding how leadership learning takes place. However, formal curricular initiatives may not be sufficient in themselves to ensure that doctors become better leaders [23]. Recognising the fundamental difference between what students are taught and what they learn, Hafferty made a distinction between the *formal curriculum*, consisting of planned and intended education programmes and instruction, and an unscripted, interpersonal form of teaching and learning, known as the *informal curriculum* [24]. Leadership learning within the informal curriculum has been researched in many areas outside medical education. For example, using the terms leadership and management interchangeably an Australian study explored how managers in a non-profit organisation had developed

their capabilities through informal learning, and Canadian researchers have explored similar themes among managers in the public-sector workforce [25, 26]. Elsewhere, a review article exploring leadership development among managers in the USA highlighted the role of informal learning, and the significance of this for those with responsibility for human resources [27]. In the context of postgraduate medical training, more specifically in General Practice, whilst formal leadership training is well researched [10,13,15], there is little consideration of the leadership learning that occurs through the informal curriculum.

Theoretical underpinnings: Relational leadership

Traditional theories of leadership can foster a leadership culture of duality within hierarchical organisational structures in which individuals are seen either as leaders or as followers [28-30]. Such an individualistic view of leadership may give prominence to leadership traits, behaviours and styles, and the qualities of a good leader [31-32]. In contrast, a relational model of leadership is seen as a collective phenomenon which values co-operation and integration, and promotes participation and involvement as the core leadership strategy [5]. Relational leadership views organisations as networks of changing individuals [33], in which leadership is broadly distributed across all levels, and in which the roles of individuals as leaders or followers may change depending on the particular situational challenge [34]. This is an accurate description of the GP training environment in the UK, in which doctors constantly build new relationships, and frequently join and leave different organisational settings each of which may experience regular turnover of staff.

Rationale and Aims of the Study

There is no doubt that effective leadership is important, necessary, and beneficial to patient care, and there may be as much need to develop effective leadership in General Practice as elsewhere in the NHS. In Scotland, primary care continues to be delivered by autonomous, multi-professional practice teams, and services generally reflect the needs of the local community [35]. In these terms, there may be much in common with the way in which secondary care is delivered. However, the culture of General Practice is somewhat different to that of secondary care institutions, and it could be argued that GPs have always valued their own sense of identity within the context of primary care [36]. The ways in which GP trainees learn about leadership at the point of GP training are therefore likely to differ from the processes of leadership learning elsewhere in the NHS. Furthermore, a broader understanding of leadership learning among GP trainees should also include a recognition of the influence of the informal curriculum as well as the formal curriculum. The aim of this research was to explore how GP trainees learn about leadership.

In the UK, qualified doctors wishing to practice independently as GPs are required to complete a three-year training programme, partly in hospital posts, but with eighteen months attached to a GP training practice [37]. In studying how these individuals (known as GP trainees) learnt about leadership in the context of their GP training practices, this research took into account the view of leadership as a relational process [38-39]. Therefore, this study focused on personal interactions and relationships, and the relational dynamics by which leadership is developed throughout the workplace, in order to ensure that relational leadership could be recognised wherever it occurred [40-41]. Recognising that trainees' understanding of leadership is influenced by role models [42] and by the level of opportunity to engage meaningfully in leadership in the workplace [43], the facilitation of leadership learning may be viewed as the shared responsibility of an entire network of relationships. However, the challenge for those

involved in medical education is to integrate leadership development into day-to-day training, and this requires a fuller understanding of how trainees learn about leadership. Therefore, this paper aims to answer the following research question: How do GP trainees learn about leadership in their GP training practices?

METHODS

This study is epistemologically grounded in social constructionism [44], on the premise that leadership learning takes place as we construct meanings through our social interactions. This epistemological position aligns with our theoretical perspective that through personal interactions and relationships, individuals contribute to the negotiation of a shared understanding of leadership [45]. Our research question was aimed at understanding how multiple interpretations of reality were related to leadership roles and processes [44]. Therefore, an interpretive approach was employed, using thematic framework analysis of individual interviews [46].

Sampling and recruitment

Following ethical and institutional approval, GP trainees from a UK Deanery and at a point immediately before or after completion of their training programme, were invited to participate in individual interviews. Maximum variation sampling was used to ensure a diversity of trainees in terms of gender, ethnicity, practice size and geographical location [47]. Initial recruitment, by e-mail through Deanery administrative assistants, led to a low uptake of participants. However, further recruitment was achieved by enlisting the support of the trainers of potential participants, and through snowballing [48].

Fifteen GP trainees agreed to participate. There were eight males and seven females, equally representative of small, medium and large practice sizes. Participants were evenly spread between urban practices and those that included a rural element. Two participants had trained on a less than full-time basis, and two were from a black, Asian or minority ethnic (BAME) background.

Data collection

Participants read a study information sheet and then provided demographic data and written consent. Single semi-structured interviews were carried out, using an interview schedule devised in line with the research question aiming to explore specific episodes of learning, with reference to the context, people involved, interactions and consequences. The geographical area of the Deanery was widespread, and remote and rural in places, so interviews were carried out using an online video conferencing method (or telephone on two occasions when internet link failed). This allowed both parties to be in a comfortable place at a planned time convenient for participants, and avoided the need for travel. The interviews were audio-recorded (with consent) as digital recording files, and transcribed by a medical secretary from JN's GP practice.

Data analysis

The data was analysed by both authors who became familiar with the data by listening to the audio-recordings while reading and re-reading the transcripts. The transcripts were checked for accuracy, and all data were anonymised. The authors employed a collaborative approach to thematic analysis [46]. First, we reviewed the transcripts separately and then discussed and negotiated key themes. We then developed a framework and coded all transcripts using Atlas-ti software (Version 7.5; Berlin, Germany).

It is usual in thematic analysis to refer to established theory, and this study interpreted the general narratives with particular regard to relational leadership theory [38-39]. The unit of thematic analysis was the participants' narrative about leadership experience. The intention was to identify common thematic elements relating to leadership learning as a relational activity in a social context, occurring through time and space. Other themes reflected rules and roles, and other aspects of the culture of a practice [24,36,49].

Data pertaining to participants' leadership learning were coded as either formal or informal learning, and categorised according to sub-themes. Where the participant evaluated the leadership learning experience either positively or negatively, this was also coded. Phrases in the narratives which indicated very specifically that the narrator had learned about leadership were categorised thematically.

RESULTS

The results are presented in three sections, each describing a different aspect of the broad spectrum of formal and informal leadership learning. In the first two sections, we describe leadership learning that arose from the formal and informal curricula. Thereafter, we describe a process of informal leadership learning based on participants' descriptions of how they learnt about leadership. In keeping with Hafferty's definition, the authors have taken the view that tutorials and attendance at partnership meetings are part of the formal curriculum, on the basis that they are planned and intended to be educational [24].

Leadership learning arising from the formal curriculum

Within the formal curriculum, participants identified learning to have taken place through courses, experience, tutorials and planned opportunities for leadership. These data are described in detail in this paper. Other formal learning opportunities included reflective learning and multi-source feedback. When participants expressed a view of a recommended formal leadership training course, their evaluation was more often negative than positive, judging them to be too focused on leadership theories and models, and unrelated to the realities of General Practice:

There is nothing really specific to GP practice itself. It is all about models and going up a ladder, and chaos theory, and all these bizarre things that don't really stay with you, then you just chuck the book in the recycling bin when you get home. (P14 Female).

Others felt strongly that those delivering the formal course should understand the role of a GP, and participants used negative emotional language such as anger, frustration and exasperation, in their responses to formal courses. Evaluation of other formal types of learning was predominantly positive. In particular, attendance at partnership meetings was universally recognised as a privileged opportunity to understand how a partnership functioned:

The practices that I have been in have been very open about having trainees in the partner meetings and you know they didn't really hold back on things. It was - one day you may be working with this, and you need to learn it now. (P12 Female).

However, some participants were discouraged from attending partnership meetings, citing business and financial sensitivities as explanations. Trainee-led small-group teaching sessions were reported to have been valuable opportunities for newcomers to learn the leadership role from their seniors:

The place I learnt most was in the small group work. Definitely, by the end of the three years training, you were involved in a leadership role there.
(P13 Female).

Half of the participants had discussed leadership in a tutorial led by a practice manager or a GP. Three participants had been given a formal opportunity for leadership, and found that this brought them into direct contact with others in the practice:

I am quite IT minded so I was encouraged to take on management of the practice intranet. It was about coming up with ideas, speaking to people who were influential within the practice and taking that idea to a meeting, and bringing it forward that way. (P6 Male).

Leadership learning arising from the informal curriculum

Within the informal curriculum, learning most frequently took place through observation, role modelling and experience, so these data shall be described in detail. Learning through reflection and informal feedback were less commonly described. When participants expressed a view, the evaluation of all types of informal learning was more often positive than negative. Participants commonly described observing leadership among the GPs, the practice manager, and various team leaders, but leadership was also observed within a team or a practice:

I think also, the time in practice has shown what good leadership within a practice does for a practice and the flip side of that when leadership doesn't quite work and how that can harm a practice and make it not as efficient as it could be. (P12 Female).

Observations of poor examples of leadership could be as rich an opportunity for learning as observations of good leadership:

I can remember some examples of bad leadership (laughter) - GPs getting angry at reception staff - so if a patient phoned up and needed to speak to someone and one GP in particular didn't like to be interrupted and so would get really angry at reception staff if they interrupted him. But then actually speaking to the GP - he explained how GPs make many more mistakes if you get interrupted and I could see his reasoning behind things, but I don't think he dealt with it very well with the reception staff necessarily. (P15 Female).

When participants identified a leadership role model it was most commonly their trainer, and they often admired commitment to patient care, service, and generosity of time. One participant captured the enduring nature of such relational aspects of leadership:

Yeah, I think I have been really fortunate through my training that I have worked with people who I really look up to and really aspire to be like them. You know, people who clearly work hard, who will kind of go the extra mile to do things, who have time for their patients, who have time for the people they are working with, and I think they are the people who I would look back and think I would like to be like them, you know in 30 years time I want to be the person who is doing that. (P10 Male).

Role models were said by other participants to '*lead by example*', to be '*inspiring*', and to be able to '*share a vision*' with others of how things could be. When informal experiential learning was identified by participants, it was noted to have occurred through incidental interactions or, as one participant put it, '*behind the scenes*':

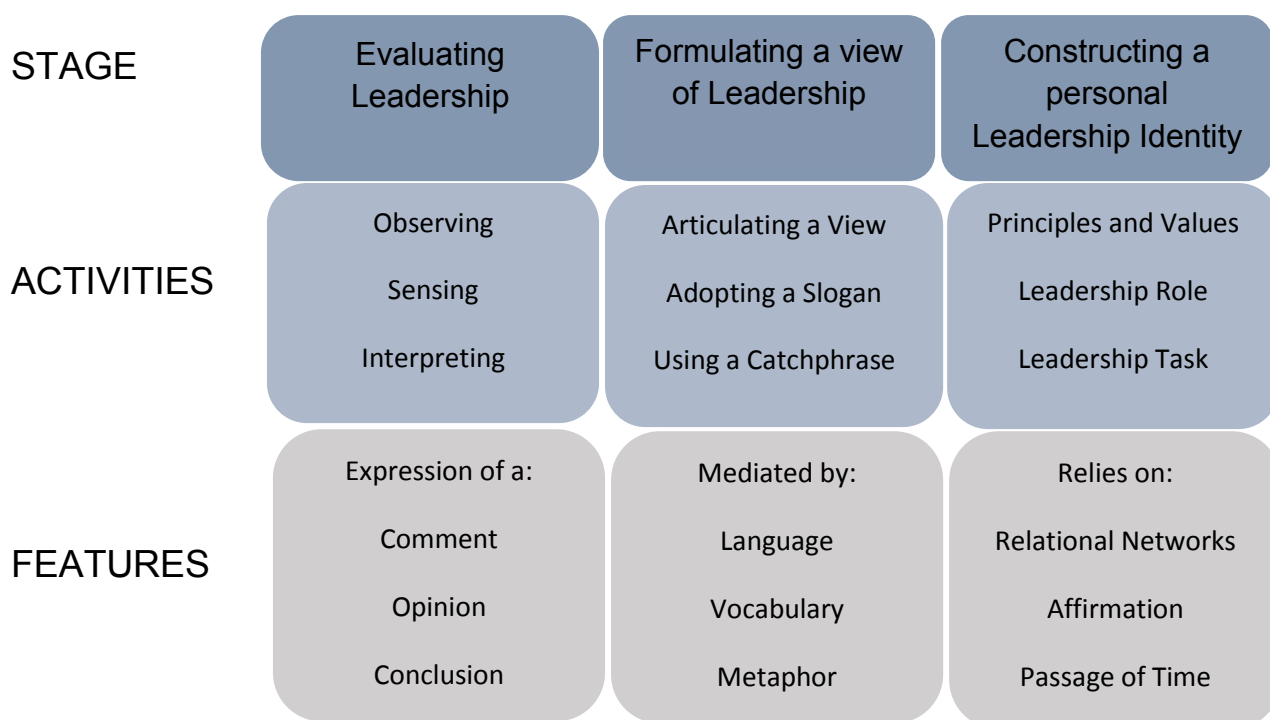
You know, being someone that the staff will come and speak to, you know, people would come and tell me sort of more behind the scene issues, and I think really doing the job is what taught me more about leadership, and how

a leader should sort of behave. I have learned things, and I think my leadership in my work has probably made me confident, not just at work but as a person as well. (P14 Female).

The Process of Informal Leadership Learning

Across the data set, distinct episodes were identified in which participants said they had learnt about leadership. These episodes can be grouped together and convey a process of informal leadership learning which includes: evaluating leadership, formulating views of leadership, and constructing a personal leadership identity. The model below (Figure 1) helps describe this process, and in the following sections we define each stage of the informal learning process.

Figure 1. A model for informal leadership learning



Evaluating leadership

The process of evaluating leadership involved several distinct activities: evaluating the leadership through observation; recognising a sense or a feeling which informed the evaluation process; and interpreting what was observed. One participant observed leadership in a GP who related effectively with staff:

He was clearly an obvious lead for the team so just watching him working amongst the staff, be it the doctors or admin, I think I probably learned quite a lot just seeing that. (P1 Female).

Participants frequently acknowledged the subjective nature of their evaluation of leadership, using phrases such as 'got a sense of' or 'became aware of'. Participants articulated their interpretations of leadership in different ways. Some offered an opinion ('everyone looks at things differently' - P9 Male) or a comment ('many individual personalities were causing the trouble' – P7 Male). Sometimes a long series of connected observations led to a conclusion ('he realised they were not on board...he got frustrated...it became tense...that is why it was not effective' – P6 Male). Finally, leadership was sometimes evaluated through its absence or omission, as in the quote below:

I think looking at why the whole thing dissolved in to a sort of chaotic situation where no one would listen to anyone, I think trying to analyse the way people behave before you go in with a strategy is probably something that I took from it. I suspect that wasn't done, I suspect they didn't think about the person that they were trying to deal with, and perhaps the manner in which it was dealt with would have been different had they thought about those sort of things first. (P14 Female).

Beginning with observation and self awareness, the process of evaluation leads to an interpretation of events, and ultimately to the second process of leadership learning – formulating a view of leadership.

Formulating a view of leadership

When formulating a view of leadership, two distinct activities took place: the articulation of a formed view of leadership; and the adoption of a leadership slogan or catchphrase. Participants commonly expressed a view of leadership in terms of its positive influence on relational activities such as interactions and communications:

Leadership is for me about how you communicate with people, good communication. How you interact with people and how you can lead a team in a certain situation. (P3 Male).

Other participants referred to the attributes of good relational leadership, such as trustworthiness, which instil a level of confidence among followers:

I think it is about other people having confidence in yourself and the decisions that you make clinically as well as sort of morally and socially and all those aspects of health and life, and I think if the team doesn't have confidence that you are making sensible, right decisions then you are not going to be a leader, you know, the team is not going to follow you, as it were. (P14 Female).

The use of leadership terminology helped to shape leadership learning both at the point of understanding and as it was articulated by the trainee. Trainees' views of leadership were influenced by the leadership language used by those around them. One participant had heard her trainer describe practices in terms of teams and groups, and

this terminology had become embedded in her understanding of working relationships in the practice:

My trainer summed it up best – ‘Oh, that practice is more of a team. Here, we are more of a group’. I often felt that everyone was there working in the same place, but not necessarily working united. You could go for a whole day working there and actually not see any other doctors. (P11 Female).

Trainees also articulated their views of leadership using a vocabulary that reflected their leadership experience:

One of the partners is kind of leading implementation of that within the practice to try and shift work that our dispensers do towards community pharmacists. So the idea is that because it is a group enterprise, if their work is less then it will be a lot less stressful within the practice and we will be able to potentially redeploy them to do other things at the same time. (P6 Male).

Participant P6 used business terminology to describe the leadership of a practice initiative to increase the involvement of community pharmacists, suggesting the project was an *enterprise*, and that staff could potentially be *redeployed*. Whether or not this was part of the practice leadership terminology, the participant's choice of vocabulary revealed something of the way in which he had formulated one of his views of leadership.

The basis of the formulated view was not always acknowledged, and had perhaps been forgotten, but the view of leadership was firmly held, and had a level of integrity in its own right. Participants readily identified with leadership slogans celebrating the visionary or motivational aspects of leadership, or the sense of responsibility that comes with leadership:

You know, being a leader is about taking responsibility for something, the leader is responsible for whatever it may be that is being undertaken. (P8 Male).

Metaphoric language was used to add impact to slogans. Thus, leaders were described as *movers and shakers* (P6 Male), *a big fish in a small pond* (P5 Male), *or a small cog in a bigger system* (P10 Male), and the nature of leadership was about *selling things* (P6 Male), *stepping up to the plate* (P2 Female), *putting your neck on the line* (P1 Female), or *leading the ship* (P5 Male). By adopting the slogan as theirs, participants spoke about leadership with a greater level of authority.

Constructing a personal leadership identity

The final stage of the process of informal leadership learning was the construction of a personal leadership identity, and involves three components: acknowledgement of leadership principles and values; clarification of a personal leadership role; and carrying out a leadership task.

Commonly expressed relational leadership values included care and compassion, approachability, inclusivity, and a willingness to stand up for what is right. When an otherwise highly regarded leader openly criticised a colleague, one participant's leadership values came to the fore and took on greater lasting significance:

Sometimes she had an attitude that I didn't like. I didn't like this as a leader or a professional. When she was in a room and talking about if she didn't like anyone. 'He is lazy, he is wasting his time', you know - her talking about another trainee. I found that attitude as a professional, as a leader, I do not like that. (P3 Male).

Other participants indicated that during their training they had come to understand their leadership role in relation to others, and embraced the responsibility that came with this. For many, leadership is simply part of the job of a GP:

It wasn't saying 'yes, that's me, I am a leader'. It was more 'this is my job and I am going to help these people', 'they have asked for my help and I am there to help people', you know - that is my job. A sense of ownership is probably what you have. This problem has been given to me, so it is my job to sort it out, rather than 'I am the boss' or 'I am the leader of this problem'.

(P14 Female).

Both the strength of relationships among those in the training practice, and the extent to which new trainees were drawn into these relationships, influenced the leadership learning experience. One participant acknowledged that it took time to develop a leadership role:

I think it is harder for me at the moment to take on the leadership role in my new practice because again people don't know me, I don't know the patients and it takes time, I think, to build up some of the network and framework to be able to take on the role. (P11 Female).

Some participants struggled with this process, and simply felt unprepared for certain leadership roles:

When I was an STI (first year of GP training) I had an occasion where I ended up looking after a palliative care patient and had to make some important decisions about their care, and I was almost in a leadership position but I felt at that point that I was not ready for that. I hadn't really got to know the district nurses at that point and I didn't know how to organise a

syringe driver and things like that. I was given that role before I really knew how to go about it. (P10 Male).

Four participants identified a specific leadership role that had been assigned to them during training. However, one participant had to actively seek out such an opportunity, and was obliged to justify his suitability for the task of teaching students:

So I went to her and said I am the best person for the student to be with, because I have got the desire, I have got the time, I have got the willingness and I am in the stage of learning. Anyway, so after that things changed so I was able to interact much more with the students. That is one way in which I stepped into a leadership position where I wasn't given one. (P9 Male).

DISCUSSION

Within the formal curriculum, the activities most likely to provide effective leadership learning include partnership meetings and tutorials, and courses in which the content relates closely to General Practice. However, a process of informal leadership learning also takes place which reflects trainees' experiences and roles, and the terminology with which leadership is described. There is value in making this informal learning more visible through discussion and reflection, so that it can inform and enhance the formal learning that takes place.

The inclusion of competency frameworks [19, 21] in formal leadership courses may usefully support individuals towards the development of a range of personal leadership competencies. However, those responsible for designing and delivering leadership courses should also acknowledge the informal learning processes by which trainees

learn about leadership. Effective courses should raise trainees' awareness of the reference system criteria by which they evaluate leadership in others, and contribute to an understanding of the vocabulary and terminology with which they articulate their views of leadership. Through an exploration of trainees' roles and responsibilities, courses could facilitate the emergence of trainees' leadership identities, both individually and collectively, and personalise the concepts of relational leadership. Leadership courses should be delivered by individuals who know and understand the various roles of those attending the course.

This study highlights the educational value of attending partnership meetings in order to understand the broader political and fiscal aspects of clinical care, and experience different approaches to leadership in these contexts. Active participation in such meetings is likely to lead to an understanding of how decisions are made and responsibilities distributed, and business or financial sensitivities should not be a barrier to such useful learning. When trainees are made to feel welcome at partnership meetings and encouraged to participate, they gain an insight into what it means to be a GP partner which can positively contribute to their emerging sense of identity as a leader. However, leadership learning is largely a series of informal learning processes, all of which can be facilitated by a GP trainer. Trainees evaluate leadership by analysing leadership attributes, styles of chairmanship, and strategies for handling conflict. When role models exhibit poor leadership, trainees may still draw useful lessons from these negative interpersonal interactions. A negative evaluation of the observed leadership behaviour may serve to add value to a trainee's own approach to leadership. It can be useful for trainees to observe that role models are subject to the strains of professional life, and an understanding of a role model's fallibility may usefully modify an unrealistic aspiration towards infallibility in leadership. Trainees also formulate a view of leadership through analysis, interpretation, and the testing of hypotheses. These processes can be difficult and bewildering, so those with direct

responsibility for training should be willing to facilitate this cognitive journey by discussing these themes in tutorials, and if necessary contributing to a co-construction of the trainee's leadership views. An exploration of trainees' use of leadership metaphors and terminology could also help them to understand the origin of some of their conceptualisations of leadership. A further role of the GP trainer is to ensure the trainee has opportunities to carry out meaningful leadership roles through which they can gain the trust and recognition of the practice community. By experiencing and discussing the relational aspects of leadership, trainees can clarify their leadership values and principles, and articulate them verbally. In this way, trainees can gradually construct their leadership identity.

Leadership learning among trainees depends on the formation of a network of interpersonal relationships, and therefore becomes the shared responsibility of the wider clinical team. It is beneficial for trainees to develop a network of trusted colleagues from whom they can receive positive feedback and affirmation of their leadership competence and identity. Such a network of relationships, in which involvement and cooperation among colleagues is valued, is the very environment in which relational leadership can flourish [5, 33]. However, it takes time to establish these networks, so for some trainees the most significant leadership learning may be expected to take place in the latter half of the training programme, and trainees who transfer to another Deanery partway through their training may require support to build up the necessary networks.

These informal processes of learning may be common to trainees in other medical specialties and in other professions, in which case the implications for leadership development may extend more widely. This opens an area of further research with the potential for multi-professional study.

Strengths and limitations of the research

To the authors' knowledge, this has been the first study to explore leadership learning among GP trainees. The authors recognise that the selection process relied on voluntary participation, and as a result the participants may have had a greater interest in leadership than GP trainees in general. However, our sample was evenly represented in terms of gender, and practice size and type. Ethnic minorities and trainees working less than full-time were represented, and there was widespread geographical representation across the Deanery. Therefore, although GP trainees in other UK Deaneries may have a different experience of leadership learning, particularly with regard to formal leadership courses, we suggest that the findings of this study may be transferable to other GP training practices in the UK.

As a GP trainer working in the same geographical area as the participants, the author enjoyed a level of "insider" knowledge and status, and an understanding of their culture and language [50]. In contrast, a significant factor that helped the researcher observe with an 'outsider' lens was the use of an online video conferencing method for interviewing [51]. By avoiding a face-to-face encounter in a GP setting, neither party could adopt their familiar identity as trainer or trainee, and this provided clarity about the purpose of the interview.

A limitation of this study is that only GP trainees were interviewed. A broader perspective may have been obtained by interviewing GP trainers and other members of the practice team, and this could be an area of further research. The cross-sectional data were collected in a single interview, and reflects participants' recollections of their experiences. Further research could explore the longitudinal development of leadership over time.

CONCLUSION

This study adds to our understanding of how GP trainees learn about leadership through the informal curriculum. We have identified a process of informal leadership learning which includes the evaluation of leadership, an articulation of leadership views, and the construction of a leadership identity. Having argued that leadership is a relational process, we suggest that in the General Practice context leadership learning is also a relational activity. Leadership learning takes place through participation in and involvement with the practice community, and relies on a network of colleagues who can contribute to and affirm the trainee's sense of leadership identity. The role of the GP trainer is to provide meaningful opportunities through which trainees can engage in this process of informal learning, and then to help them to reflect on and understand their experiences of leadership. In this way, leadership learning can be integrated into the day to day activities of GP training.

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